STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185200	A. BUILDING _____ B. WING _____	01/19/2011

RECEIVED
MAR 12 2011
Division of Health Care
Southern Enforcement Branch

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LETCHER MANOR	73 PIEDMONT DRIVE, P O BOX 747 WHITESBURG, KY 41858

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on January 17-19, 2011. Deficient practice was identified with the highest scope and severity being at "E" level. An abbreviated standard survey (KY15770) was also conducted at this time. The allegation was substantiated but no deficiencies were cited related to the allegation.	F 000	Letcher Manor does not believe nor does the facility admit that any deficiencies exist. Letcher Manor reserves all rights to contest the survey findings through informal dispute resolution, appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Letcher Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Letcher Manor does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Letcher Manor offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents. Letcher Manor strives to provide the highest quality of care while ensuring the rights and safety of all residents.	
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide for maintenance of comfortable sound levels. Loud noise was observed from pill crushers during medication administration at the A station when staff was crushing resident medications. The findings include: Observations of the F hall conducted on January 17, 2011, at 5:45 p.m., revealed loud metal on metal noise when a Licensed Practical Nurse was utilizing a pill crusher to crush resident medications. A group interview conducted with ten alert and oriented residents on January 18, 2011, at 10:00 a.m., revealed the facility was noisy and the mornings were worse because of the pill	F 258	F258 483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS Letcher Manor strives to provide a comfortable environment for our residents. It is the policy of this facility to maintain comfortable sound levels that do not interfere with residents' hearing, enhance privacy when privacy is desired, and encourage interaction when social participation is desired. Staff is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla E. Disney	Administrator	3/9/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	185200	A. BUILDING _____ B. WING _____	C 01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LETCHER MANOR	73 PIEDMONT DRIVE, P O BOX 747 WHITESBURG, KY 41858

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F 258	Continued From page 1 crushers. An individual interview conducted with resident #13 on January 17, 2011, at 6:15 p.m., revealed the banging was loud when the nurses were crushing medications in the hallway. The resident stated, "It sounded like someone was using a hammer to beat on the wall." Interviews conducted on January 18, 2011, from 4:00 to 4:10 p.m., with two Licensed Practical Nurses (LPNs) who administered medications at the A station revealed the LPNs were not aware of excessive noise from the pill crushers and would set the pill crusher on the medication administration book to reduce the sound; however, this action made crushing the residents' medications difficult. Further interview revealed the residents often mistook the pill crusher for someone knocking on the door and would often say, "Come in."	F 258	educated to the policy, to keep sound level so as not to disturb residents; to refrain from making loud noises, talking loud or shouting, and to keep the atmosphere calm, organized and as quiet as possible. However, due to the medical condition of several residents, it is necessary for the nursing staff to crush resident medications in order for some residents to ingest their medications. The equipment used to crush the medication is made specifically for crushing medications. The amount of time residents are exposed to noise with the pill crusher is minimal. This is evidenced as follows: 1. Resident #13 medical records do not reflect this resident made any staff aware that sound levels were a discomfort or distraction prior to this survey. The pill crusher equipment was replaced with alternative pill crushing equipment that has minimal noise, to ensure comfortable sound levels. Per interview with Resident #13, the noise level is acceptable and is not an issue. 2. The facility interviewed all alert and oriented residents to ensure that any/all residents were comfortable with sound levels. No residents were identified to have a concern with noise level. Should the concern arise for noise level, the facility policy shall be implemented. 3. An educational in-service was held on February 4, 2010, with all staff regarding facility policy for maintaining comfortable sound levels. Staff sensitivity and awareness of noise levels were also topic. All new hires shall be oriented to the policy upon orientation; and the policy shall be reviewed with staff if or when a concern is	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible.	F 323		

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F 323	Continued From page 2 Observation during the environmental tour revealed the facility failed to ensure disinfectant spray, hand sanitizer, shaving cream, perineal cleanser, and gallon containers of shampoo/body wash were secured/locked and not accessible to residents. The findings include: Observation during the environmental tour on January 17, 2011, at 5:45 p.m., and on January 18, 2011, at 4:30 p.m., revealed an unsecured/unlocked corner cabinet in the men's Central Bath located on the D Hall that contained the following: a partially used spray container of Virex Tb disinfectant, a full container (7.5 ounces) of Derma Rite Perifresh (perineal cleanser), one full/unused 8-ounce container of Proadvantage Shampoo/Body Wash, one partially used 8-ounce container of Proadvantage Shampoo/Body Wash, two containers of Fresh Scent shaving cream, and a 4-ounce bottle of hand sanitizer. Further observation of the shower room revealed partially used 1-gallon containers of Proadvantage Shampoo/Body Wash stored on the floor in shower stalls #1 and #3. The gallon containers did not have lids. Review of the facility's Census and Condition Record dated January 17, 2011, revealed 38 residents had a diagnosis of Dementia. Review of the facility's list of residents that were assessed to be at risk for wandering/elopement revealed 13 residents were at risk. Further observation revealed 15 resident rooms had a velcro/alarm-activated stop sign door guard applied to the entry door frame to prevent wandering residents from entering other	F 323	identified. In addition to in-servicing staff, the monthly resident council meetings shall encourage discussion of any noise level issues, to ensure this issue does not recur. 4. To ensure solutions are sustained in regards to the above, the Director of Nursing shall implement Quality Assurance measures to review quarterly, the adherence to facility policy for noise control. The review will include face-to-face interviews with 10 percent of facility residents. Evaluation reports will be distributed to the Administrator for review and appropriate action taken as necessary. 5. **F 258** February 4, 2011 F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISON/DEVICES It is the policy of Letcher Manor to provide an environment free of accident hazard. For a material to pose a safety hazard to a resident, it must be toxic (cause death, temporary incapacitation or permanent harm), caustic (capable of burning, corroding or destroying live tissue) or allergenic (causing hypersensitive reaction, but not intrinsically harmful). Per facility policy, cleaning supplies shall be stored as instructed on the labels of such products. This is evidenced by the following actions: 1. No resident was found to have been affected. However, all products were removed from accessible areas on January 18, 2011 from the reported area and were stored behind locked areas. 2. All resident areas were assessed for any/all accessible hazardous items. Any located were removed and properly stored on January 18, 2011. No residents with diagnosis of dementia or wandering	2/4/11

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	185200	A. BUILDING _____ B. WING _____	C 01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LETCHER MANOR	73 PIEDMONT DRIVE, P O BOX 747 WHITESBURG, KY 41858

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F 323	Continued From page 3 residents' rooms. Review of the Material Safety Data Sheet (MSDS) for the Virex Tb Disinfectant revealed misuse of the disinfectant could cause moderate eye and skin irritation and if ingested could cause abdominal discomfort, nausea, and vomiting, and one should seek emergency medical attention immediately if this chemical was ingested. Further review of the MSDS information for Proadvantage Shampoo/Body Wash revealed the product may cause moderate irritation to the eyes and if ingested may result in gastric disturbances. Review of the MSDS information for hand sanitizer revealed the product was flammable, and may cause eye irritation, upset stomach, and nausea. The MSDS directed if the product was ingested not to induce vomiting and to contact a physician or Poison Control Center. Interview on January 18, 2011, at 4:30 p.m., with the Unit Coordinator (UC) revealed the housekeepers kept all disinfectants locked/secured. The UC stated if a disinfectant was needed in the shower rooms, it could be obtained from the housekeepers but should be returned to the housekeeper after use. The UC stated residents should not have access to any chemicals. The UC stated the shower rooms were checked during rounds that were conducted every two hours. The UC stated Virex had a warning label on the container that stated the product would be harmful to residents. Review of the facility policy entitled Storage Areas failed to reveal instructions related to storage of cleaning supplies or personal hygiene products.	F 323	tendencies have gone into the shower area unassisted. All safety measures will be implemented per policy, as well as staff education to be performed. 3. To ensure potential resident accessibility of hazardous chemical or hygiene products does not occur, the facility policy was updated to address accessibility of hazardous materials. Education was provided to all staff regarding facility policy on February 4, 2011. New employees shall also be orientated to the facility policy. All resident areas potentially affected shall have locked areas made accessible for hazardous material storage. The Director of Nursing, or her designee, shall be notified immediately of any deviation from policy, and shall be immediately corrected. 4. To ensure solutions are sustained in regards to the above, the Director of Nursing shall implement Quality Assurance measures to monitor for effectiveness of the policy and to modify safety interventions as necessary. The SRNA Preceptor shall monitor the respective areas on a daily basis and report immediately to the Director of Nursing any variance of policy. In addition, the Administrative Nurse shall randomly audit safety practices each month for each resident area and shall report immediately to the Director of Nursing any area in need of corrective measure. Evaluation reports will be distributed to the Safety Committee for review and appropriate action taken as necessary. 5. N 219 February 4, 2011	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		2/4/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 4 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label	F 431	F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Letcher Manor strives to provide services that are being met with accepted professional principles, which include labeling of drugs and biologicals, in accordance with accepted professional principles, by appropriate qualified persons to include licensed nurses for medication administration and Consultant Pharmacists for proper resident assessments and recommendations; as well as establishment of a system of records for drugs and biologicals. This is evidenced by the following actions: 1. No resident was found to have been affected. The one (1) vial of Novolog Insulin that did not have a label or date, was removed from the cart and discarded as immediate corrective action on January 19, 2011. 2. No residents were found to have medications not labeled or dated. All medication carts and medication areas were assessed on January 19, 2011, for any/all medications without appropriate labeling or dates. No other medications were located. 3. To ensure the practice will not recur, an educational in-service was held on February 4, 2010, with nursing staff regarding facility policy and procedure for appropriate records for medications. All new hires shall be oriented to the policy; and the policy shall be reviewed with staff if or when a concern is identified. 4. To ensure solutions are sustained in regards to the above, the Director of Nursing shall implement Quality Assurance measures to review quarterly, the adherence to facility policy for labeling and	

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F 431	Continued From page 5 and date all drugs and biologicals in accordance with currently accepted professional principles. One vial of Novolog Insulin intended for multi-dose use had been opened and was available for use; however, the medication had not been labeled and dated to indicate the date the bottle was opened and which resident the medication was intended for. The findings include: Observation on January 19, 2011, at 3:00 p.m., of the facility's medication rooms/carts revealed a vial of Novolog Insulin had been opened and remained available for resident use. Further observation revealed the vial failed to indicate the date the vial was opened and failed to contain a label stating which resident the medication was intended for. An interview was conducted with the Director of Nursing (DON) on January 19, 2011, at 3:10 p.m. The DON stated the medication should have been labeled and dated at the time the medication was opened. The DON further stated he/she felt the medication had probably been taken out of the STAT box. The DON stated nurses could pull medications out of the STAT box if needed, but were required to label the medication with the name of the resident the medication would be used for, and place the date the medication was opened on the vial. The facility failed to provide a policy regarding the requirement of dating and labeling of multi-dose vials of medication.	F 431	dating drugs and biological. Continued observation of medication carts and medication areas will be done periodically through a quality assurance check on a monthly basis. Evaluation reports will be distributed to the Director of Nursing for review and appropriate action taken as necessary. 5. **F 431** February 4, 2011 F465 483.70(h) SAFE / FUNCTIONAL / SANITARY / COMFORTABLE ENVIRONMENT It is the policy of Letcher Manor to provide an environment that is safe, functional, sanitary and comfortable for residents, staff and the public. All personnel are formally trained and orientated on this policy. There is a formal preventative maintenance program and also a formal work order system in place. The preventative maintenance program is performed with routine check-lists for daily, weekly, monthly, quarterly and annual checks of equipment and facilities. At the time of survey, all such routine checks had been conducted and were current. Staff is required to report areas in need of repair on a Maintenance Request Form. These requests are addressed and completed as to priority. This is evidenced by the following actions: 1. The facility is not aware of any resident having an adverse affect from any of the issues noted during the environmental tour. All areas of observation or concern for rooms numbered 182, 175, 110,165, 161 and 154 were addressed and completed effective January 18, 2011.	2/4/11
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	2. The facility has made further environmental observation throughout the facility on all areas noted during the environmental tour.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 6 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A fall mat was observed to have ragged/torn edges, a toilet bowl had a brownish stain around the rim, a commode was observed to run continuously, a resident's bathroom door would not close without excessive force, a overbed light activation string was to short for the resident to use, and a overbed light covering was observed to be chipped. The findings include: During the environmental tour of the facility on January 17, 2011, the following items were observed to be in need of repair: -The fall mat in resident room 182 had ragged/torn edges. -The commode in resident room 175 was running continuously. -The wallpaper/drywall was marred/torn in resident room 165. -The bathroom door in resident room 161 would not close without excessive force. -The overbed light activation string in resident room 154 was to short for the resident to utilize. -The overbed light covering was chipped in resident room 154.	F 465	There were no further issues or potential for residents to be affected. 3. All staff were re-educated on February 4, 2010 regarding the procedures related to initiating Maintenance Request Forms and proper execution of such. Staff was also educated regarding a safe, functional, sanitary and comfortable environment and their responsibilities thereof. 4. To monitor the effectiveness of housekeeping and maintenance services, the Director of Nursing shall implement as part of the Quality Assurance process, involvement of the Safety Committee. The Safety Committee shall provide monthly inspections throughout the facility relating to safe, functional, sanitary and comfortable environment; and at random, shall select designated areas for review. The Safety Committee results, and any other environmental issues found, shall be reported to the Administrator at the time of the occurrence, so corrective measures may be taken. 5. **F 465** February 4, 2011	2/4/11

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F 465	Continued From page 7 -The rim of the toilet bowl in resident room 110 had a brownish stain. Interview on January 19, 2010, at 1:15 p.m., with the Maintenance Supervisor (MS) revealed the facility utilized a work order system. The MS stated any staff member could obtain a work order at the nurses stations to inform the maintenance department of any thing that needed repaired. The MS stated the MS made rounds once a day to check water temperatures and look for items in need of repair; however, the MS was not aware of the identified areas.	F 465		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185200	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/18/2011

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on January 18, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Letcher Manor does not believe nor does the facility admit that any deficiencies exist. Letcher Manor reserves all rights to contest the survey findings through informal dispute resolution, appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Letcher Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Letcher Manor does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Letcher Manor offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents. Letcher Manor strives to provide the highest quality of care while ensuring the rights and safety of all residents.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to utilize proper access doors in the fire/smoke wall assembly in the attic area. This deficient practice affected four of five smoke compartments, staff, and approximately ninety residents. The facility has the capacity for 142 beds with a census of 119 on the day of the survey. The findings include:	K 025	K025 NFPA 101 LIFE SAFETY CODE STANDARD Letcher Manor has contracted with a Professional Service for which they are responsible for quarterly and annual inspections, and for notifying the facility of any deficient area in need of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carla E. Dishner, Administrator | 2-10-11

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K 025	Continued From page 1 Observation during the Life Safety Code survey on January 18, 2011, at 12:20 p.m., with the Director of Maintenance (DOM) revealed the facility had an unapproved makeshift access door in the rated fire/smoke barrier wall in the attic area of the F corridor. This type of access door is required to be of an approved device that is designed for the specific purpose to help prevent fire/smoke from spreading to other areas of the building in a fire situation. An interview with the DOM on January 18, 2011, at 12:20 p.m., revealed the DOM was not aware this access door was deficient. The DOM stated there were also unapproved access doors in the A and E corridor attic areas as well. Reference: NFPA 101 (2000 Edition). 8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (3) 1/2-hour fire barrier - 20-minute fire protection rating (1) 2-hour fire barrier - 11/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42	K 025	There were makeshift access doors constructed of fire rated sheet rock, and were secured and in place at the time of survey. New fire-rated UL approved metal attic access doors have been ordered and will be installed immediately upon arrival to the facility. Until such time as installation is complete, maintenance shall perform routine inspection of the area. **K025** February 4, 2010	2-4-11